400 N. Pepper Avenue, Colton, CA 92324 Phone: (800) 442-4978 Fax: (909) 580-2459

Welcome to ArrowCare

This handbook is designed to help with questions you may have about services covered through ArrowCare. It offers resource to you about accessing care and what your rights and responsibilities are under this program. ArrowCare is a federally-funded program that provides medical care to those people who met certain requirements and are living within the San Bernardino County boundaries. Under this program you are assigned to a Primary Care Provider (PCP), who not only takes care of you when you are sick, but also for regular and preventive care to help you stay healthy.

Your Rights

As an ArrowCare Member, you have the following rights to:

- Receive information about ArrowCare and about your rights and responsibilities as an ArrowCare Member.
- Be treated with respect and courtesy. ArrowCare recognizes your dignity and right to privacy.
- Receive interpreter services at no cost to you.
- Receive medically necessary covered services without regard to race, religion, age, gender, national origin, disability, sexual orientation, medical condition, or stage of illness.
- Receive emergency and/or post stabilization services in and out of your network hospital and not incur liability for payment of these services.
- Receive services at Federally Qualified Health Centers.
- Receive sensitive services, such as mental health care, confidentially.
- Receive information from ArrowCare that you can understand.
- Make recommendations about ArrowCare's Members' rights and responsibilities policies.
- Participate with Doctors in decision making about your own health care.
- Talk with your Doctor about your medical condition and appropriate or medically necessary treatment options regardless of the cost or what your benefits are.
- Decide about your care, including the decision to stop treatment or services, or stop participating in health management programs.
- Decide in advance how you want to be cared for if you have a life-threatening illness or injury.
- Keep your personal and medical information and records confidential.

- Complain about ArrowCare, it's Providers, or your care. ArrowCare will help you with the process. You may appeal decisions made by ArrowCare. You have the right to choose someone to represent you during the grievance process.
- Have ArrowCare act as your patient advocate.
- Request a second opinion about a medical condition.
- Disenroll from ArrowCare.

Your Responsibilities

As an ArrowCare Member, you have the following responsibilities to:

- Cooperate with your health care provider and follow your Doctor's instructions.
- Keep your provider and the Transitional Assistance Department (TAD) advised of any change in your financial circumstances or of any change in your living arrangements, such as address. Please be aware, if it is learned that you received benefits to which you were not entitled, you may be required to repay the plan.
- Ensure that when treated/admitted to an out-of-network Emergency Room that ArrowCare is notified within 24 hours of the service by contacting ArrowCare at (800) 442-4978.
- Be familiar with and ask questions about your health plan coverage.
- Request interpreter services at least 5 business days before a scheduled appointment.
- Call your Doctor or Pharmacy at least 3 days before you run out of medicine.
- Call your Doctor when you need routine or urgent health care.
- Avoid knowingly spreading disease to others.
- Use ArrowCare's grievance process to file a complaint.
- Understand there are risks in receiving health care and limits to what can be done for you medically.
- Notify ArrowCare and your Doctor if you want to stop the plans and instructions you have agreed on.

Program Benefits and Limitations

Your health is our priority, and many services accompany this program that will help keep you healthy. Certain services, such as visits to a Specialist, are covered ONLY on referral from your Primary Care Physician along with prior authorization from the ArrowCare, if required. ArrowCare will only cover prescription medications that are medically necessary and ordered by a participating Provider. Prescriptions ordered by your Primary Care Physician, or physicians at ARMC, must be filled at the Outpatient Pharmacy located at ARMC. Home delivery for prescription services is available. Remember, medicine that can be bought without a prescription, such as over the counter (OTC), is not a covered benefit, except in certain limited situations.

ArrowCare provides comprehensive medical benefits and coverage to its Members. Your benefits as an ArrowCare Member include the following: Doctor's services, inpatient hospital services, home health services, preventive health services, emergency health care services, mental health services, diabetes coverage, and prosthetic services among others. Contact the ArrowCare Member Services at (800) 442-4978, or visit www.ArrowCare.org, for a complete listing of available services and service limitations.

ArrowCare members are not subject to co-pays, deductibles, or cost-sharing for covered benefits received from network providers, or authorized out-of-network emergency services.

You can start getting care when you become a member of the ArrowCare. Your membership card is enclosed with this package. Please keep this card with you at all times as it must be shown to your health care provider before you can get care. A replacement card is available upon request if you lose your card.

You may access care 24/7 by contacting your assigned primary care doctor. If you don't know if the injury or illness is an Emergency, call your doctor or the ArrowCare Nurse Advice Line at (800) 442-4978 after hours, on the weekends, and holidays. In the event of an emergency during non-business hours, please go to the nearest emergency room for service.

Your Doctor

As an ArrowCare Member you are assigned to a Primary Care Doctor. Your Doctor is sometimes referred to as a Primary Care Physician (PCP). If you have any questions about your Doctor's qualifications, you can call the Member Services Department at (800) 442-4978. Your Doctor takes care of or helps to arrange for your health care needs. Your Doctor also keeps important records about your health and any medical conditions that you may have. When you need ANY type of medical care, except emergency or out-of-area urgent services, call your Doctor so that you can receive expert advice.

If you move or if you find that your Doctor does not meet your needs, you may wish to change your Doctor. You are able to change your PCP once every twelve (12) months following the initial enrollment. You can change your Doctor by calling the Member Services Department at (800) 442-4978. When you change your Doctor, you may also be changing the other Providers you can see. You should ask your Doctor if a new referral is needed.

To view a directory of all network Primary Care Providers, please visit www.ArrowCare.org. A paper copy may be requested by contacting Member Services at (800) 442-4978.

Mental Health

Mental Health treats many things including depression, anxiety, serious family issues, and other mental health problems. Mental Health care is just like any other type of care. Your Doctor can provide you some services. For other services you may need to see a Specialist. Mental Health services are limited to individuals with a significant impairment in an important area of life functioning, or a probability of significant deterioration in an important area of life functioning.

Members are entitled to up to 10 days per year of acute inpatient hospitalization in an acute care hospital, psychiatric hospital, or psychiatric health facility, psychiatric pharmaceuticals, and up to 12 outpatient encounters per year.

For inpatient and outpatient mental health conditions that are beyond the scope of your Doctor, you will be directed to the San Bernardino County Department of Behavioral Health or the San Bernardino County Mental Health Program (MPH).

If you feel you have a mental health problem, you may contact the San Bernardino County MHP directly at (888) 743-1478. This is a toll-free telephone number that is available 24 hours a day, 7 days a week. You do not need to see your regular doctor first or get permission or a referral before you call.

Members with Developmental Disabilities

If your Doctor tells you that you have a developmental disability (e.g., difficulty with learning and/or motor skills), you may be eligible for Inland Regional Center's Services. Please call you Doctor or ArrowCare Member Services at (800) 442-4978 for more information or a referral.

Getting Family Planning Services

Male and female ArrowCare Members in the childbearing years can get Family Planning Services from a qualified Provider in the Family PACT program without authorization or referral. Family planning helps you choose how many children you want and when you want to have them. All Family Planning Services are confidential.

How to Get Medical Care

For most of your health care needs, see your Primary Care Provider first. If you have an emergency, call 911 or go to the nearest Emergency Room. Appointment times vary based upon your medical condition. If you go to an Emergency Room, make sure the staff at the Emergency Room calls to notify ArrowCare of your treatment within 24 hours of the service.

Your Primary Care Provider's (PCP) may be found on you ArrowCare I.D. Card or by calling the ArrowCare Member Services Department at (800) 442-4978. Call your PCP to make an appointment. Your PCP will care for you or refer you to a Specialist if needed.

Certain services may need to be performed by another Provider. In these cases, your PCP will request a referral for you. A referral lets you get special services your PCP cannot provide. Your PCP will discuss your health care needs with you, and, if medically necessary, refer you to another Provider, such as a Specialist. Your PCP will start the referral process. You MUST get a referral BEFORE you receive specialty services.

You DO NOT Need a Referral:

- To see your Primary Care Doctor (PCP),
- To get care for an emergency medical condition,
- To test for HIV, or tests or services for sexually transmitted diseases (STDs),
- Well woman exams
- Immunizations

A special kind of referral called a Standing Referral is a request from your Doctor to a Specialist when you require specialty care over a long period. Examples of some conditions that could need a Standing Referral are long term wound care, significant heart disease, and multiple sclerosis. Extended Access to Specialty Care is a request to a Specialist or specialty care center when you have a life-threatening, degenerative, or disabling condition that requires coordination of your care by a Specialist. Examples of some conditions that could need Extended Access to Specialty Care are HIV, AIDS, and cancer.

Referrals may be denied. If the referral, treatment, or hospital stay is NOT approved by ArrowCare's Utilization Management Committee and/or Medical Director, you will receive an explanation. The Utilization Management Committee and/or Medical Director will send you a denial letter explaining the decision and how you can file a grievance if you disagree with the decision.

A Second Opinion is another special kind of referral that lets you get another Doctor's opinion of your medical condition. You can ask your Doctor for a Second Opinion. If you feel uncomfortable asking your Doctor or your Doctor refuses to start the process, call the Member Services Department at (800) 442-4978.
If you have a chronic problem like asthma, cancer, diabetes, heart disease, lung disease, kidney disease, AIDS, hepatitis C, spinal injuries, or other chronic problems, Care Management Nurses can help you manage your disease by working with your PCP and Specialists to manage your medications and assist you in getting medical equipment. If you are interested in learning more, contact the ArrowCare Member Services Department.

Grievance Process

We want you to be healthy and satisfied by the services provided. To that end, we encourage you to direct any questions or concerns that you may have to your Primary Care Physician (PCP). If you would like to file a grievance related to a reduction, termination, or denial of coverage or payment for medical assistance, or service delays, or the quality of care you received, or if you have any other related concerns, you may do so by contacting our office.

Examples of Grievances

- You are not satisfied with ArrowCare's or a Provider's service
- You believe there was a problem with your medical care or you did not get the service you needed
- You believe your linguistic needs are not being met
- You believe you were incorrectly denied medical services or treatment

How to Get Started

1. You can call the ArrowCare Member Service at (800) 442-4978 or use our "Member Complaint Form." All our Doctor's office and service Providers have the form or we can mail one to you. If you need help completing the form, you may call ArrowCare Member Services at (800) 442-4978. You can mail the completed form to us at the address listed at the front of this booklet.

2. If you receive a Notice of Action (denial letter) from ArrowCare, you have three options for filing a grievance. A Notice of Action is a formal letter telling you that a medical service has been denied, deferred, or modified.
    - You have ninety (90) days from the date of the Notice of Action to file an appeal with ArrowCare.
    - You may request a State Fair Hearing from the Department of Social Services (DSS) within (90) days.
    - You may request and Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC).
3. You can also file a grievance that is not about a Notice of Action. You must file your grievance within one hundred (180) days from the day the incident or action occurred which caused you to be dissatisfied.
4. We will send you a letter within 5 days, letting you know we received your grievance. We will work to resolve the complaint and we may contact you or your Provider for more information.
5. The entire process will be resolved within 30 days. ArrowCare will send you a letter explaining our decision within this time.
6. Urgent grievances involve an imminent and serious threat to your health, including, but not limited to severe pain, potential loss of life, limb, or major bodily function, and are resolved within 72 hours from the date that we received your grievance. ArrowCare will immediately notify you of the right to contact the Department of Managed Health Care (DMHC) regarding the urgent grievance. There is no requirement that you participate in ArrowCare's grievance process prior to submitting a grievance you consider urgent to the DMHC for review.

If You Are Still Unhappy Or Feel You Have An Urgent Grievance You May:

•Appeal an adverse grievance decision made by ArrowCare, by calling ArrowCare Member Services at (800) 442-4978. You may also submit your appeal request to us at the address listed at the front of this booklet, by fax at (909) 580-2459.

•Request a State Fair hearing within 90 days from the date of Notice of Action letter or an occurrence that caused you to express dissatisfaction. If your grievance is urgent to you must ask for an expedited fair hearing 10 days from the date of the letter or occurrence. You can file a State Fair Hearing before, during or

after filing a grievance with ArrowCare, whether or not the grievance was resolved by ArrowCare. The telephone number is 1-800-952-5253 or TTY 1-800-952-8349 or by mail to California Department of Social Services State hearing Division, P.O. Box 944243 Mail Station 19-37 Sacramento, CA 94244-2430.

•Contact the Department of Health Care Services Ombudsman Unit at 1-888-452-8609 at any time. You can represent yourself at the State Fair Hearing. If you choose, a friend, an attorney, or other person may represent you, but you must arrange this yourself. The Public Inquiry and Response Unit at (800) 952-5253 can help you find legal help.

•Contact the Department of Managed Health Care 30 days after you filed a grievance at 1-888-HMO-2219 or for TDD 1-877-688-9891 (http://www.hmohelp.ca.gov). You may contact them immediately if you have an "Urgent Grievance" as discussed above.

The California Department of Managed Health Care is responsible for regulating health care services plans. If you have a grievance against your health plan, you should first telephone your health plan at (800) 442-4978 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decision for treatment that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www/hmohelp.ca.gov has complaint forms and IMR applications forms and instructions online.

Your Grievance Rights

1. If your grievance concerns are a serious threat to your health, we will resolve it within 72 hours. All other grievances are resolved within 30 days.
2. You have the right to ask ArrowCare to help you work with your Provider or anyone else to fix your problem.
3. You have the right to change your Providers.
4. You have the right to ask a relative or someone else to help file your grievance and represent you during the grievance process. Grievances can be registered or filed by parents, guardians, conservator, relative, Doctor, or other designee. Grievances can also be filed on behalf of the Member if the Member is a minor or an adult who is otherwise incapacitated. Relatives include parents, stepparents, spouse, adult son or daughter, grandparents, brother, sister, uncle, or aunt.
5. You have the right to disenroll from ArrowCare without giving a reason.
6. You have the right to submit written comments, documents or other information in support of your grievance.
7. You may contact other state agencies for help.

Independent Medical Review

An Independent Medical Review is when the Department of Managed Health Care (DMHC) reviews a Health Plan's decision to deny, delay, or modify a service your Doctor requests. There is no cost for this service and a determination will be made in writing within 30 days of DMHC's receipt of your completed application or less if determined that an expedited review is necessary. If your request concerns are imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb, or major bodily function, or

immediate and serious deterioration of your health, you will get results within 72 hours. "Subject to the approval of the department, the deadlines for analysis and determination involving both regular and expedited reviews may be extended by the Department of Managed Health Care up to three days in extraordinary circumstances for good cause." For more information about an Independent Medical Review, contact ArrowCare Member Services at (800) 442-4978.

You may request an Independent Medical Review (IMR) of disputed health care services from the Department of Managed Health Care if you believe that health care services have been improperly denied, modified, or delayed. A "disputed health care services" is any health care service eligible for coverage and payment that has been denied, modified, or delayed, in whole or in part because the service is not medically necessary. You may request an IMR if you have applied for a State Fair Hearing.

The IMR is in addition to any other procedures or remedies available to you. You pay no application or processing fees for an IMR. You have the right to provide information in support of the request for an IMR. ArrowCare must provide you with an IMR application form with any grievance disposition letter that denied, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against ArrowCare regarding the disputed health care service.

Your Application for an IMR will be reviewed by the DMHC to confirm that:

1. Your Provider has recommended a health care service as medically necessary, or
2. You have received urgent care or emergency services that a Provider determined was medically necessary, or
3. You have been seen by an in-plan Provider for the diagnosis or treatment of the medical condition for which you seek independent review.
4. The disputed health care service has been denied, modified, or delayed by the plan or one of its contracting Providers, based in whole or in part on a decision that the health care service is not medically necessary, and
5. You have filed a grievance with the plan or its contracting Provider and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review, you may bring it immediately to the Department's attention. The DMHC may waive the requirement that you follow the Plan's grievance process in extraordinary and compelling cases. You are not required to participate in ArrowCare's grievance process for more than 30 days; and for cases involving an expedited review, you are not required to participate in ArrowCare's grievance process for more than three (3) days.

If your case is eligible for an IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is medically necessary, ArrowCare will ensure that the health care service is provided.

Independent Review for Experimental or Investigational Therapies

If you qualify, you can request an independent review for denied experimental or investigational therapy or treatment. To qualify you must meet each of these main requirements:

1. Your Doctor must certify that you have a life-threatening or seriously debilitating condition. "Life-threatening" means either or both of the following:
   (a) Disease or condition where the likelihood of death is high unless the course of the disease is interrupted:
   (b) Disease or condition with potentially fatal outcomes, where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity.
2. Your Doctor must certify that you have a life-threatening or seriously debilitating condition as defined above from which:

(a) Standard therapies have not been effective in improving your condition;
(b) Standard therapies would not be medically appropriate for you; or
(c) There is no more beneficial standard therapy covered by ArrowCare than the therapy proposed pursuant to paragraph (3).

3. Either (a) your Doctor has recommended a drug, device, procedure or other therapy that the Doctor certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Specialist (board eligible or certified) has requested a therapy that, based on two documents from the medical and scientific evidence, is likely to be more beneficial to you than any available standard therapy.
4. ArrowCare or one of its delegated Providers has denied the requested medication, device, procedure, or other therapy.
5. The specific medication, device, procedure or therapy recommended would be a covered service, except for the determination that the therapy is experimental or investigational.

You are not required to participate in ArrowCare's grievance process before requesting an independent review for experimental or investigation therapy.

The list gives you some but not all the requirements. If we deny coverage for service, ArrowCare will notify you in writing of the opportunity to request an independent review within 5 business days. If your Doctor determines that the proposed therapy would be significantly less effective if not promptly initiated, the independent review organization designated by the DMHC must provide its determination within 30 days of receipt of you application and supporting documents. For urgent cases, the independent review organization must provide its determination within 3 days.

You may contact ArrowCare Member Services at (800) 442-4978 for more information regarding the independent review process, or to request an application form.

Ending of Your Benefits

If any of the following occurs, your medical coverage with ArrowCare will stop:

- Your age exceeds the qualifying age limit
- You are no longer able to provide proof of legal residency or citizenship
- You voluntarily disenroll from ArrowCare
- TAD determines your financial circumstance has changed no longer making you eligible
- Your behavior is such that it threatens the safety of ArrowCare, Providers, or Members
- You move out of the San Bernardino County boundaries

If you are disenrolled from ArrowCare due to loss of eligibility, you may be eligible in the future to reapply for ArrowCare. Please see your TAD eligibility worker at the local Transitional Assistance office for more information.

Your health care coverage may not be canceled because of your health. If you think your coverage was cancelled because of a health concern, you can request the Director of the California Department of Managed Health Care to review your case. You can request review of your case by calling 1-800-400-0815. All ArrowCare Members also have the right to a fair hearing. If you feel your ArrowCare enrollment was cancelled because of a health reason, you can call the California Department of Social Services' Public Inquiry and Response Unit at 1-800-952-5253 and ask for a fair hearing.

Member Services Information

For more information, or if you have any questions regarding your eligibility, or have a complaint or concern, please call the Member Services Department at (800) 442-4978. Phone calls may be monitored or recorded. Department representatives speak English and Spanish, and interpreter services are available for more than 100 other languages. You have the right to request interpreter services when discussing medical information. In-person interpreters (sign language or foreign language) are available; however, we request that you provide us with sufficient notice of at least 5 business days before your scheduled appointment. Interpreter services are available free of charge. You have the right to use family members or friends as interpreters. Minors should not be used as interpreters unless it is a medical emergency. You can file a grievance if you feel your linguistic needs are not met.

Prescriptions: Information about the ArrowCare Approved List of Medication and Drugs (The ArrowCare Formulary)

ArrowCare has a list of pre-approved drugs called a Formulary. The fact that a drug is on the Formulary does not guarantee you will prescribed that drug. If your prescription is for a drug that is not on the ArrowCare Formulary, your Doctor or the ARMC Pharmacy will contact ArrowCare and submit a **Non Formulary Authorization Request Form.** ArrowCare will reply to the completed form within 24 hours, Monday through Friday. If you need a prescription filled after business hours, on weekends, or on holidays, your pharmacy will dispense a sufficient supply of formulary and non-formulary medication when medically necessary.

Medications included in ArrowCare's Formulary may have FDA-approved generic equivalents available. ArrowCare mandates generic dispensation for all quality generic products. If your Doctor indicates that you need a brand name drug, instead of a generic, your provider will need to submit a Non Formulary Authorization Request Form to request ArrowCare's approval of dispensing the brand name drug.

Sometimes the pharmacist must get additional information from your Doctor. This may delay the pharmacist from submitting the request to ArrowCare. If a delay is expected, ArrowCare authorizes enough medication to last you up to 72 hours while any problems are cleared up with your Doctor and ARMC pharmacy.

Prior authorization is not required, when medications are prescribed in emergent or urgent circumstances. ArrowCare ensures that a sufficient supply (at least 3 days) of medication is dispensed to ArrowCare Members at Emergency Room (ED) upon discharge. All hospitals are obligated to provide starter packs as needed to ArrowCare Members upon discharge from ED or hospital, until the Member can reasonably be expected to have a prescription filled at the ARMC pharmacy.

If you need a refill on your prescription, call your Doctor or pharmacy at least 3 days before you run out of medication. If you are completely out of medically necessary medication, your pharmacist may give you enough medication to last until the refill is authorized or denied.

For a copy of the ArrowCare formulary, please visit www.ArrowCare.org. A paper copy may be requested by contacting Member Services at (800) 442-4978.

Adult Wellness Services

As an ArrowCare Member, you are encouraged to improve your health. You can do this by taking advantage of the health services offered to you. You can call 2-1-1 for community resources for San Bernardino County. If you need help in finding community resources, you can call ArrowCare Member Services at (800) 442-4978 or ask your Doctor.

Exclusions

- Any services obtained outside the United States.
- Services that are NOT covered benefits, even if your Doctor has referred you. These services may include, but are not limited to the following:
    - •Organ Transplant
    - •Bariatric Surgery
    - •Infertility Related Services

Alternate formats of this document are available upon request.